

Certificate of Need Regulation of Home Health and Hospice Services in the United States



MARYLAND HEALTH CARE COMMISSION

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Preface

Reliable comparable nationwide data on health care program operations have become increasingly difficult to obtain over the last couple of decades. State licensing, data collection and reporting, and regulatory policies have changed, and diverged, as Federal requirements have been lifted or relaxed. Hence, the necessity of ad hoc surveys if up-to-date information is needed or required.

This study was undertaken to ascertain the current--year 2000--status of CON regulation of home health and hospice services nationwide, and where possible to determine the principal effects, if any, of differing regulatory postures among states. Resource and time constraints limited both the scope and the depth of study. These limitations aside, the information presented may be of use to those interested in, or affected by, the development and operation of home health and hospice services. It reveals a broad range of regulation patterns, and related operational experiences, over the last 25 years.

The Commission appreciates greatly the cooperation and assistance of the scores of state officials and long-term care organization representatives nationwide who contributed their time and knowledge. Without their generous support this study could not have been completed. Special thanks are due to the American Health Planning Association, to the current and former state certificate of need officials contacted, and to the principal authors of this report, Dean Montgomery and Thomas Piper. Their efforts and diligence helped ensure that information from all fifty states and the District of Columbia were made available. The Commission thanks each and all of them.

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I. Introduction

Public policy regarding certificate of need (CON) regulation of health services and facilities, now in its fourth decade in some states, remains unsettled. The value of such regulation continues to be debated, now more than twenty-five years after implementation of CON programs nationally under the National Health Planning and Resources Development Act of 1974. The nature and intensity of these debates have changed little, even with the guidance that more than a quarter century of experience provides. Legislators, health care officials, and other policymakers, under pressure to improve access to care and to constrain costs, assess periodically the costs and benefits of regulation. Enthusiasm for certificate of need regulation ebbs and flows accordingly. Currently, thirty-six states and the District of Columbia have statutes authorizing CON programs.¹ The services and facilities regulated under these programs vary considerably regionally and from state to state.

Home health and hospice care are two of the services often regulated under CON programs. Neither service was a major component of the health care system when most state CON programs were established in the mid 1970s, but they were usually included, implicitly or by direct reference, as a regulated service when programs were instituted. More than two-thirds of states regulated both home health care agencies and hospice services by the early 1980s. Demand for both services accelerated during the early years of CON regulation.

Notwithstanding the growing economic and clinical significance of both services in recent years, particularly of home health care, a growing number of states have removed them from the list of covered services. This may have occurred because effective regulation of these services under established state CON programs is problematic. In contrast to many institutional and high technology health services, market entry for these services is relatively easy and capital requirements are comparatively low. Because of their non-institutional orientation, capacity constraints are even more difficult to implement than market entry controls. These services can expand and contract capacity merely by adding or reducing staff, which is not regulated in any form under CON. In addition, both can be developed as distinct, dedicated services or as components of established acute care and long-term nursing care services.

Although regulating these services effectively is problematic, eliminating all oversight raises equally difficult questions. Many of those in need of home health and hospice services are among the most economically vulnerable and are unusually dependent upon providers of health care services. They often need the protection that state

regulation of these and other health services affords. As more states look toward market solutions to manage and otherwise regulate market entry and day-to-day operations of health care services, a growing number of them have opted to remove home health care and hospice services from CON regulation. States now considering relaxing or eliminating CON controls on home health and hospice services may benefit from the experience of those that have confronted this question over the last decade.

II. Methods and Data

This study was commissioned to identify current CON regulatory patterns for home health and hospice services nationwide, to document the duration and scope of that regulation, and to the extent practicable, to identify and assess the effects of regulatory changes over the last decade and a half on service capacity, use and expenditure levels in selected states. A national survey was undertaken to collect data and information documenting the historic and current CON regulatory posture of each state. Customized questionnaires were sent electronically and via U. S. mail to CON program officials in each state and the District of Columbia. The survey instrument was designed for flexible use, as a written form to be completed and returned in writing or electronically (e-mail), and as a form for use in structured telephone interviews, as necessary. Unresponsive addressees were contacted via e-mail and telephonically over the ensuing six weeks to assure complete responses. Ultimately, all fifty states and the District of Columbia provided usable information.

Information requested focused on the current status of CON regulation of home health, hospice and nursing home services in each state. Data were obtained to document the dates CON coverage was initiated and terminated (if applicable), the imposition of moratoria or other market entry barriers other than CON, special or unusual licensing requirements, and the role of state Medicaid programs, if any, in controlling market entry and capacity. Appendix C contains a copy of the survey instrument.

As originally designed and intended, the information obtained from the baseline survey was to be augmented with that obtained in a second survey of selected “case study” states. As with the initial basic survey, customized questionnaires were to be sent electronically and via U. S. mail to CON program officials in the selected states. Case study states were to be six states that eliminated CON controls on home health and hospice services between 1986 and 1996. To the extent practicable, these studies were to be structured to examine three regulatory combinations among states:

- two states that eliminated CON regulation of home health services, but not of hospice services;

- two states that eliminated CON regulation of hospice services, but not of home health services; and
- two states that eliminated CON regulation on both home health and hospice services.

The baseline survey revealed that no combination of states fits the first two categories. This unexpected outcome occurred because a number of states never instituted CON regulation of home health agencies, hospice services, or both. Initial survey results show that states eliminating CON regulation of home health services either also dropped regulation of hospice services or never regulated hospice services under their CON programs. Similarly, states that eliminated regulation of hospice services also ceased regulation of home health services or never instituted CON regulation of the service.

Given the results of the baseline survey, only states that either eliminated regulation of both services or never regulated either service were selected for customized follow-up surveys. Seven states fitting these categories were selected for additional data collection. These interviews were scheduled over the span of two weeks. Appendix C contains copies of the select case study state questionnaires.

Publicly available state level home health and hospice service operational data were obtained from the Health Care Financing Administration and correlated with state CON program changes to assess the possible consequences of the regulatory changes reported. Data were obtained for all states rather than just those meeting the criteria for case study follow-up surveys. These data were aggregated and presented in three categories: those continuing to regulate the service, those eliminating CON regulation, and those that never instituted CON regulation. The data and information presented covers many of the questions that the case study survey was intended to address. A number of gross capacity, use, and economic effects were observed.

Unless otherwise indicated, the data presented is for Medicare and Medicaid certified facilities and services for fee-for-service patients. These are the only facilities and services for which comparable national data are available over the study period.

III. Home Health Care, 1965 – 2000

Home care has long been an essential element of health care, first as an array of informal health and health-related support services provided by family and friends, and more recently as a defined set of services provided by professional home care agencies. Formally organized home care services in the United States date from the 1880s. The number of agencies grew slowly, if steadily, until the mid 1960s when the total reached more than 1,000 nationwide. The prototypical modern home health

agency, with its emphasis on skilled nursing services, physical and occupational therapy and professional monitoring of patients, began with the development of a hospital-based home care program at Montefiore Hospital in New York City in 1947.² This model prevailed for many years and was later emulated by the thousands of public, voluntary not-for-profit, and proprietary agencies that arose in the 1970s and 1980s.

As with many other health services, enactment of the Medicare program in 1965, and later development of state Medicaid programs, provided a needed stable economic base of support for home health services. This, in turn, stimulated increased demand for home health services and corresponding growth in the number and capacity of home health agencies. Medicare and Medicaid coverage made home health services, especially skilled nursing care and therapy, available to the needy elderly, those most in need of these services. Home health care benefits have been part of the Medicare program since its inception, and have been extended to a wider set of beneficiaries as the program has been expanded, notably to younger disabled enrollees in 1973 (1972 amendments to the Social Security Act). The effect of Medicare program support for home health services can be seen in the explosive growth in the number of certified agencies in the three decades following enactment of the program: from 1,753 agencies in 1967 to a peak of 10,807 in 1997 (Table 1), a more than five fold increase.³

Table 1 Medicare Certified Home Care Agencies, by Type United States, 1967 – 1999									
Freestanding Agencies					Facility-Based Agencies				
Year	Visiting Nurse Association	Public	Proprietar y	Private Non Profit	Other	Hospital	Rehabi- litation Facility	Skilled Nursing Facility	Total
1967	549	939	0	0	132	133	0	0	1,753
1975	525	1,228	47	0	155	273	9	5	2,242
1980	515	1,260	186	484	103	359	8	9	2,924
1985	514	1,205	1,943	832	63	1,277	20	129	5,983
1990	474	985	1,884	710	47	1,486	8	101	5,695
1991	476	941	1,970	701	41	1,537	9	105	5,780
1992	530	1,083	1,962	637	80	1,623	3	86	6,004
1993	594	1,196	2,146	558	87	1,809	1	106	6,497
1994	586	1,146	2,892	597	93	2,081	3	123	7,521
1995	575	1,182	3,951	667	105	2,470	4	166	9,120
1996	576	1,177	4,658	695	92	2,634	4	191	10,027
1997	553	1,149	5,387	715	98	2,698	3	204	10,807
1998	460	968	3,414	610	104	2,356	2	166	8,080
1999	452	918	3,192	621	100	2,300	1	163	7,747
Source: Health Care Financing Administration, Center for Information Systems, 1999.									

Home health care was largely a non-profit industry in 1965, with a large percentage of agencies depending upon charitable contributions and other subsidies. Initially, the Medicare program required as a condition of participation that proprietary home health agencies be licensed in the state where they offered services. Because few states licensed home health agencies at that time, most proprietary agencies were excluded from Medicare participation. This restriction was lifted in 1980, leading to an increase of more than ten fold in the number of proprietary Medicare-certified home health agencies between 1980 and 1985, and another doubling of the number over the next decade (Table 1). By 1997, about one-half of all certified agencies (5,387 of 10,807) were freestanding proprietary agencies.⁴ The proportion that is proprietary varies considerably from state to state.

Over the last 25 years, home health care has emerged as a viable alternative to institutional care in many instances. By some definitions, there are now more than 20,000 home care organizations nationwide, about 40 percent of which are Medicare certified home health agencies.⁵ These organizations serve between 6 and 9 million people each year. Skilled nursing care, physical therapy, medication monitoring, and supportive personal care and homemaker services are provided each day to the 1.5 to 2.0 million persons 65 years of age and older who receive home health care services from a Medicare certified home health agency. Demand increases substantially with age. Those 85 years of age and older, for example, have use levels 4 to 5 times higher than those between 65 and 74 years of age. Women have higher use levels than men among all elderly age groups.⁶

In addition to liberalizing provider participation, Medicare home health coverage was expanded substantially in the 1970s and 1980s. The 1972 amendments to the Social Security Act extended benefits to persons under 65 years of age with qualifying disabilities or end stage renal disease, and eliminated the 20% coinsurance for Part B home health services (no hospital stay required). The Omnibus Budget Reconciliation Act (OBRA) of 1980 effectively created an unlimited home health care benefit for qualifying Medicare beneficiaries. It not only lifted the restriction on participation by for-profit agencies, but also exempted beneficiaries from all cost sharing, eliminated the distinction between Part A and Part B for coverage and payment, and removed the 100 visits per year limits. Not surprisingly, home health care demand and expenditures began to grow dramatically. Between 1980 and 1985, the percentage of Medicare enrollees receiving home health services increased from 3.4 percent to 5.1 percent, and expenditures nearly doubled, going from about \$1.5 to \$2.7 billion (constant dollars).⁷

Uncontrolled demand and spending increases prompted the Health Care Financing Administration (HCFA) to attempt to control demand and outlays by tightening coverage criteria. Medicare's stricter interpretation of coverage criteria and consequent denial of benefits to enrollees led to a class action lawsuit (*Duggan vs Bowen*, 1987) that the Medicare enrollee plaintiffs won. The settlement resulted in

further broadening of home health care coverage criteria, leading to a larger number of beneficiaries and a higher number of visits per beneficiary. As might be expected, the result was another surge in demand and expenditures. Between 1990 and 1997, the percentage of Medicare enrollees obtaining home health care services nearly doubled (growing from 5.8% to 10.8%), the average annual number of visits per home health user more than doubled (growing from 36 to 73), and total expenditures increased more than three fold, jumping from about \$4.6 billion in 1990 to about \$16.7 billion in 1997 [constant dollars].⁸

Dramatic increases in demand largely reflected the legitimate needs of a growing and aging Medicare population, as well as improvements in medical technology, pharmaceuticals and progressive clinical practices that made it possible to serve larger numbers of patients at home. It became apparent by the mid 1990s, however, that a considerable percentage of the increased demand was suspect. Consequently, in 1995 the U.S. General Accounting Office and the DHHS Office of the Inspector General began investigations under the title "Operation Restore Trust" to determine the magnitude of the problem and to combat the waste, fraud and abuse uncovered. The two-year campaign focused on activities in California, Florida, Illinois, New York and Texas, the five states with large numbers of Medicare and Medicaid enrollees and large numbers of home health agencies.⁹

Combined with burgeoning expenditures, documentation of significant levels of fraud and program abuse provided the rationale for the sweeping changes in home health care benefits incorporated in the Balanced Budget Act (BBA) of 1997. The legislation provides for a prospective payment system for home health care (scheduled to be implemented in October, 2000) and established an interim payment system with cost limits and other controls and incentives intended to promote efficiency, discourage unnecessary use, reduce the wide unexplained variation in use among and across states, and moderate the rapid growth in total expenditures. Although the number of visits for each beneficiary was not limited, the changes were designed to return overall program use and expenditures to 1994 levels, a reduction of between 20 and 25 percent (see data in Table 2).

These changes, combined with Operation Restore Trust, have had dramatic effects on home health use and on Medicare home health care expenditures. Some studies suggested that the new interim payment limits would result in the overwhelming majority of agencies having sizable operating losses unless service and practice patterns were changed.¹⁰ The concerns were warranted. Between 1997 and 1999 the number of certified agencies fell from 10,807 to 7,747 (Table 1), a decrease of about 28%. Total spending for home health care is difficult to estimate because of erratic and incomplete reporting by and among non-certified agencies. The National Association for Home Care estimates total expenditures were about 41 billion in 1997 and fell to 36 billion in 1999, largely as a result of the reduction in Medicare use and

Table 2 Medicare Fee-for-Service Home Health Care Services United States, 1994 – 1998						
Year	Home Health Agencies	Home Care Patients (Thousands)	Home Care Visits (Thousands)	Home Care Visits per Patient	Total Expenditures (Millions)	Expenditures per Patient
1994	7,521	3,197	208,759	66	\$12,676	\$3,977
1995	9,120	3,475	249,584	72	\$15,421	\$4,438
1996	10,027	3,598	264,553	74	\$16,789	\$4,666
1997	10,807	3,554	257,751	73	\$16,723	\$4,705
1998	8,080	3,062	154,992	51	\$10,446	\$3,412
Source: Health Care Financing Administration, HCIS, 1999.						

payments.¹¹ Medicare spending fell from about \$16.7 billion in 1997 to about \$10.5 in 1998 (Table 2). This extraordinary reduction reflects, fewer agencies serving fewer patients and providing fewer visits per patient served (Tables 1 and 2).

Though not nearly as large as Medicare, the Medicaid program provides a substantial amount of home health care to program beneficiaries, particularly the elderly poor. Medicaid provides traditional skilled nursing and therapy services, as well as a variety of other home care benefits under personal care and community-based waiver options. Both the number of patients served and expenditures have risen rapidly over the last 25 years (Table 3). In 1997, nearly 10% of total Medicaid expenditures were for home health services.

Table 3 Total Medicaid Patients and Expenditures United States, 1975 – 1997					
Year	Home Care Patients (Thousands)	Expenditures (Millions)	Year	Home Care Patients (Thousands)	Expenditures (Millions)
1975	343	\$70	1993	1,067	\$5,601
1980	392	\$332	1994	1,376	\$7,049
1985	535	\$1,120	1995	1,639	\$9,406
1990	719	\$3,404	1996	1,633	\$10,583
1991	812	\$4,101	1997	1,861	\$12,237
1992	926	\$4,888			
Source: Health Care Financing Administration, Division of Medicaid Statistics, 1999.					

Many home health agencies provide home care to hospice patients. Hospice home health care is an optional Medicaid service in 42 states.

IV. Hospice Care, 1973 - 2000

Hospice services are distinct from most other health and health-related services in that the objective is not curative therapy, but the provision of pain relief, comfort and other support services to the terminally ill. The concept of hospice as a place of comfort and rest dates to at least the middle ages, but efforts to develop formal hospice services in the United States did not begin until the 1960s. Initially, these efforts were usually modeled on hospice programs developed in England, and elsewhere in Europe.

Hospice programs usually have two basic components: a large home care outpatient component and a limited inpatient component. Home care is emphasized as the preferable form of hospice care for both humanistic and economic reasons. Provided the necessary supportive services are available, terminally ill patients are likely to be more comfortable at home, in familiar surroundings and among family and friends. Home care also permits hospice patients to maintain their regular lifestyles as long as possible. Circumstances under which home care may not be appropriate or possible include:

- Patients with difficult to manage pain and other symptoms that make care at home problematic;
- Patients without family or friends able or willing to provide the continuous care needed by many hospice patients; and
- Patients requiring special procedures or equipment not easily made available in home settings.

In these cases, patients may be cared for in small inpatient units operated directly by the hospice, or provided independently, or under contract, by a nursing home or hospital.

The first U. S. hospice opened in New Haven, Connecticut in 1974. It began as a home care program, with support from a National Cancer Institute demonstration grant. An inpatient component was added in 1978. The first full service hospice, offering both home and inpatient care, was established in Tucson, Arizona in 1977.

Impediments to the development of hospice programs nationwide were both cultural and economic. The U. S. health care system focuses on remedial and curative therapies, and insurance and other payment mechanisms are similarly oriented. Consequently, until recently there was comparatively little professional interest in, or

economic support for, hospice programs. With little prospect for economic gain, the proprietary health care sector, too, had comparatively little interest in promoting the service. Voluntary charitable organizations and interests provided the early impetus for development. Many programs continue to require substantial subsidization.

Economic support for hospice care began to improve significantly in 1980 when Medicare program changes permitted states without home health care licensing laws to certify for-profit agencies for Medicare participation.¹² Hospice care became a covered service under the Medicare program with the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which became effective in 1983. Coverage under the Medicaid program was added in 1985. A majority of state Medicaid programs now cover hospice services. Increasingly, private insurance plans have begun to offer hospice coverage as well.

Hospice care as defined and covered under Medicare is a specified set of services for beneficiaries who are terminally ill. Services include both home and inpatient care, when needed, and a variety of related support services not available to other Medicare beneficiaries. All Medicare Part A beneficiaries are eligible for hospice care, provided a physician certifies that the beneficiary is terminally ill with a life expectancy of 6 months or less, the beneficiary chooses to receive care from a hospice rather than standard Medicare benefits for the terminal illness, and the care is provided by a participating Medicare hospice provider.¹³ There are no deductibles under the hospice benefit. Other than a small coinsurance premium for outpatient drugs and inpatient respite care, the beneficiary does not pay for Medicare-covered services for the terminal illness.

With Medicare, Medicaid and growing private insurance coverage of hospice care, the numbers of hospice programs and patients have grown dramatically since the early 1980s. Between 1984 and 2000, the number of Medicare-certified hospice programs grew from 31 to 2,288 (Table 4). Medicare-certified hospices may be home health agency based, skilled nursing facility based, hospital based, or freestanding. Currently, more than one-third (39%) are freestanding programs, about one-third (35%) are home health agency based, one fourth (25%) are hospital based, and only 1% are nursing home based.¹⁴ Over the decade between 1988 and 1997, the number of patients served in certified hospices grew from 40,356 to 374,723 (Table 5). The majority of beneficiaries, about 52%, received care from freestanding programs, with about 30% served by home health agencies and about 18% served by hospital based programs. Less than one percent was served in programs based in nursing homes.¹⁵

Table 4 Medicare Certified Hospices U. S., 1984 – 1998					
Year	Home Health Agency	Hospital	Nursing Home	Freestanding Service	Total
1984*					31
1985*					158
1986	113	54	10	68	245
1987	155	101	11	122	389
1988	213	138	11	191	553
1989	286	182	13	220	701
1990	313	221	12	260	806
1991	325	282	10	394	1,011
1992	334	291	10	404	1,039
1993	438	341	10	499	1,288
1994	583	401	12	608	1,604
1995	699	460	19	679	1,857
1996	815	526	22	791	2,154
1997	823	561	22	868	2,274
1998	811	564	22	890	2,288
*Only aggregate data available. Source: Health Care Financing Administration, Office of Information Services, September 1998.					

Beginning in 1985, hospice services became an optional covered service in state Medicaid programs. Four states (Florida, Kentucky, Mississippi and Minnesota) added the service soon thereafter. In the ensuing decade, 39 additional states and the District of Columbia instituted coverage. Seven state Medicaid programs do not currently cover hospice care. Maryland began coverage in 1989. As with Medicare program use and payments, hospice patients and expenditures represent a very small percentage of total Medicaid program use and outlays. Both use and expenditure levels are less than one percent of Medicaid program totals. In contrast to Medicare program use and expenditure patterns, only about 10% of Medicaid program expenditures for hospice care were made to freestanding hospice and home health programs. A majority of Medicaid outlays go to hospitals, nursing homes and physicians.

Those receiving hospice care generally are elderly, but not disproportionately so when compared with other long-term care recipients. In 1996, slightly more than two-thirds (68%) were 65 years of age and older. Other demographic characteristics are generally consistent with underlying population distributions: most hospice patients are married, are about evenly divided between men and women, and the racial distributions are proportionate to overall population distribution patterns. As might be expected, chronic debilitating conditions and co-morbidities predominate among

hospice patients. More than 70% of those served had some form of cancer, and about two-thirds had two or more chronic condition diagnoses on admission. In addition to cancer, Alzheimer's disease, Parkinson's disease, and AIDS/HIV are other common diagnoses.¹⁶

Table 5 Medicare Certified Hospices U. S., 1988 – 1997					
Year	Number of Hospices	Number of Patients	Average Days per Patient	Medicare Outlays (Millions)	Medicaid Outlays (Millions)
1988	553	40,356	37.2	\$118.4	\$3.9
1989	701	60,802	44.8	\$205.4	\$18.9
1990	806	76,491	48.4	\$308.8	\$20.2
1991	1,011	108,413	44.5	\$445.4	\$44.1
1992	1,039	156,583	56.1	\$853.6	\$84.2
1993	1,288	202,768	57.2	\$1,151.9	\$128.9
1994	1,604	221,849	58.9	\$1,316.7	\$197.6
1995	1,857	302,608	58.8	\$1,830.5	\$283.5
1996	2,154	338,273	54.5	\$1,994.0	\$318.7
1997	2,274	374,723	50.1	\$2,024.5	\$327.3
Source: Health Care Financing Administration, Office of the Actuary, Center for Health Plans and Providers. April 1999.					

Aside from humanistic concerns for the terminally ill, hospice care like home health care generally is promoted because it is believed to be cost effective. Public and private studies have shown that Medicare saves about \$1.26 for each \$1.00 spent on hospice services, and that the savings result largely from the substitution of home care services for inpatient services. The savings were notable for all enrollment periods, but were greatest among those with shorter enrollment periods. Savings for those enrolled for less than one month (the patient died within 30 days) were \$1.65 for each dollar spent, compared with \$0.86 for patients enrolled for between 150 and 180 days. Subsequent studies have confirmed these estimates.¹⁷ Other studies indicate that some cost savings associated with hospice care are unrealized because terminally ill patients often delay entering hospice care until a few days or weeks before dying, and that earlier enrollment could improve care and decrease costs.¹⁸

About 15% of those dying each year receive hospice care. The difficulty of predicting the time of death and the reticence of caregivers, patients and family to accept a terminal prognosis may account for the low use levels. More important than cost-effectiveness, hospice care appears to offer a more humane and compassionate way of delivering needed services to those near death. Studies suggest that as many as

40% of seriously ill persons who die outside of hospice care experienced prolonged severe pain and that about 25% showed signs of moderate to great anxiety and depression before dying. Hospice care may alleviate some of these problems, and there appears to be strong public support for hospice care as an alternative to traditional institutional care. Survey data indicate that the overwhelming majority of adults, nearly 90%, express a preference for hospice type care in lieu of hospital or nursing home care, if faced with a terminal illness.¹⁹

Though relatively small as a percentage of total outlays, the hospice benefit payment under Medicare has experienced rapid growth during the past eight years. Medicare hospice benefit payment data show that, in 1988, the program paid an estimated \$118 million. By 1997, Medicare benefit payments for hospice care had increased to \$2.0 billion, more than a twenty-fold difference (Table 5). Most of this growth is accounted for by increases in the number of beneficiaries using the hospice benefit, rather than an increase in the average benefit payment.

In 1997, about 375,000 Medicare beneficiaries received hospice care and nearly 19 million days of care. The average number of covered days of care per person served was about 50, and the average payment per person was about \$5,500.

Medicare-certified hospices may be home health agency based, skilled nursing facility based, hospital based, or freestanding. The 1997 distributions of hospice patients, Medicare expenditures, and average numbers of days of care provided by type of hospice are shown in Table 6.

Table 6 Medicare Hospice Patients and Outlays, By Type, 1997			
Type of Agency	Number of Patients	Average Days per Patient	Percent of Outlays
Freestanding	193,765	53.4	55.5%
Home Health Agency	109,723	45.9	26.8%
Hospital-Based	68,688	17.1	17.1%
Nursing Home-Based	2,547	39.9	0.6%
Total	374,723	50.1	100%
Source: Health Care Financing Administration, Office of the Actuary, Center for Health Plans and Providers. April 1999.			

V. State CON Regulation Patterns

A. Home Health Care

States have used CON to manage the development of health care facilities and services for more than 25 years. A few states established programs in the late 1960s, and virtually all others adopted them by the end of the 1970s. Many of those established after the mid 1970s were adopted in response to the National Health Planning and Resources Development Act (PL 93- 641) of 1974, which tied eligibility to receive certain federal public health service grant funds to the adoption of state CON programs. By 1980, all states except Louisiana had adopted conforming programs. Maryland, one of the earlier states to establish a CON program, has regulated most hospital and nursing home services since 1968.

Regulatory patterns for home health care and hospice services differ from those for most other services in a number of important respects:

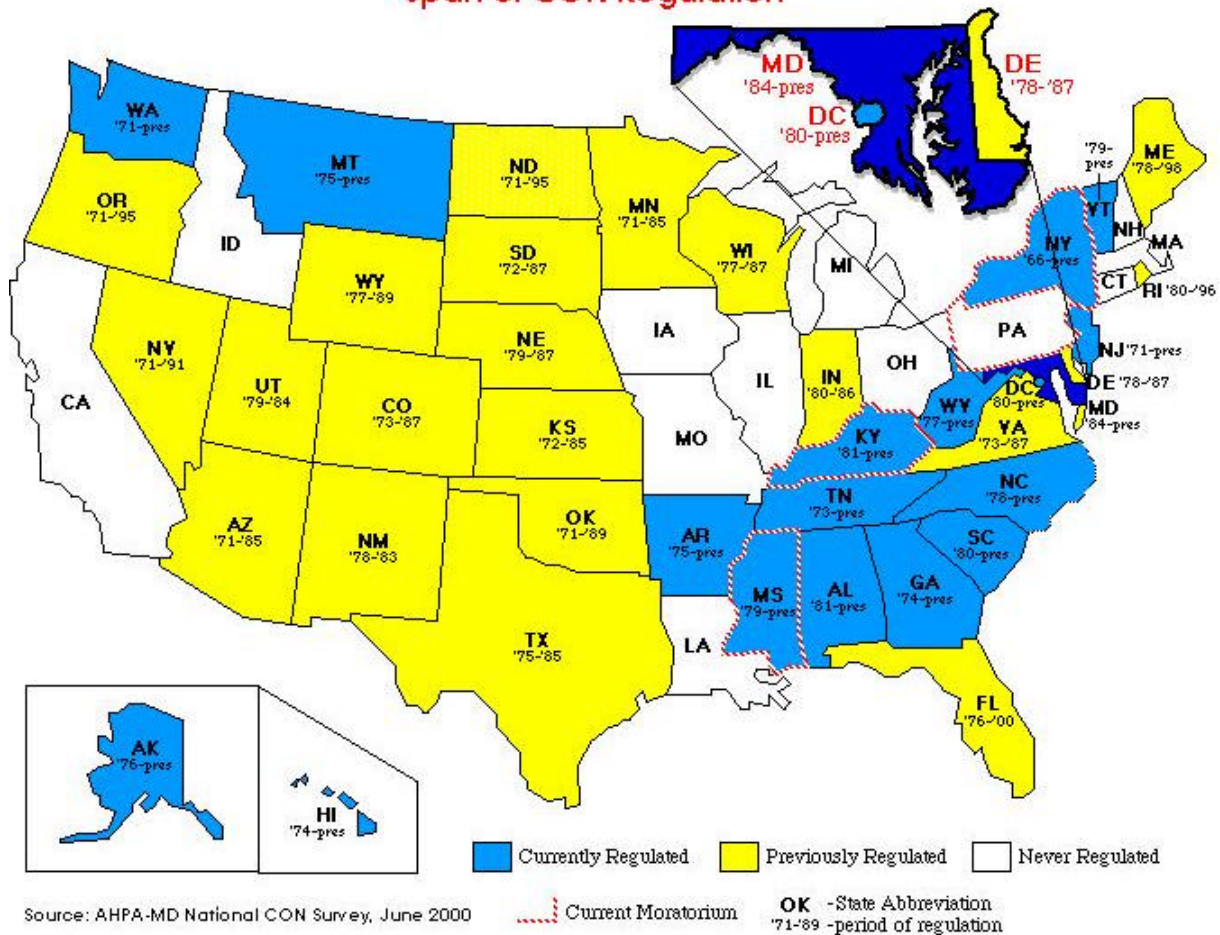
- A substantial number of states have never regulated either service;
- States that have reduced or eliminated CON regulation have dropped regulation of home health and hospice services more frequently than other regulated services;
- The duration of CON regulation of these services is relatively short; and
- Comparatively few states have replaced CON regulation of these services with another form of market entry or capacity management.

Tables A1 – A9 (Attachment A) categorize states by year 2000 regulatory status for home health services, delineate the duration of CON regulation for each state, and present related resource and use data by state.

Unlike hospital and nursing home services, a majority of states either have never regulated home health services under CON or have terminated CON regulation over the last 15 years. Federal health planning requirements did not mandate state CON coverage of home health services. Consequently, the CON programs adopted in twelve (12) states did not provide for regulation of home health agencies. Thirty-eight states and the District of Columbia initially included home health care as a regulated service in their CON programs. Subsequently, 20 states have eliminated CON coverage of home health agencies. The large majority of these states, 11 of 20 states, dropped regulation between 1985 and 1987, the period when Federal support for CON programs was terminated. Two dropped planning controls in 1983 and 1984, and six more recently in the 1990s (see Tables A1 - A9, Appendix A and Map I, Appendix B).

MAP I: Home Health Agencies (1966-2000)

Span of CON Regulation



Home health care was not a major component of the health care delivery system in 1968 when Maryland established its CON program. Maryland did not extend coverage to home health agencies until 1984.¹ It was the last (most recent) state to do so. Consequently, among the states that now regulate the service, Maryland has regulated home health agencies for the shortest period of time.

¹ Amendments to the CON statute in 1982 instituted coverage on new home health agencies and hospice programs, but clarifying language delineating how the regulatory requirements would apply to home health services was not added until 1984. That language provided that CON approval would be required for the expansion of existing home health agencies, as well as for new agencies. Similar clarify language for hospice services was added in 1987. The timing and nature of these changes may have had substantial effects on the growth of these services, many of which had been established in hospitals and nursing homes before Medicare payment became available to proprietary home health agencies.

The span of CON regulation of home health agencies decreased as the clinical and economic significance of home health care rose. Nearly half of the states that regulated home health agency development dropped CON coverage between 1984 and 1997. During that period the number of home health agencies more than doubled, and the numbers of home health patients and home health visits increased several fold. Expenditures grew even more rapidly.²⁰

Substantial deregulation of home health agencies appears to have occurred for a number of complex and interrelated reasons. First, it occurred during a period when opposition to regulation was growing at both the national and state levels, culminating in 1986 with the elimination of Federal support for CON programs. Second, regulation of home health capacity under CON is inherently difficult. Although the number of authorized (licensed) agencies can be controlled, the actual supply of the service and the functional capacity of authorized agencies are not easily controlled. Once authorized to provide home health care services, any agency can effectively expand by adding staff, subcontracting services, or otherwise enhancing its ability to serve more patients and provide a wider array of services. Third, home health services are not capital intensive. As a basic outpatient nursing and therapy service delivered in the patient's home, they do not require substantial facilities, major medical equipment, or other institutional support. They require small capital outlays, if any, and fixed costs are relatively low. Hence, they do not match closely the economic profiles and characteristics of most other facilities and services regulated under CON programs.

Only 19 states now regulate home health agencies under CON, but historical use patterns and trends suggest that such regulation may have restrained growth. Regulation of home health agencies appears to have helped restrain excess growth in the number of agencies established nationwide between 1990 and 1997, a period now shown to have been marked by both rapid legitimate growth in demand and by a number of excesses. The number of certified agencies increased by about 90% nationwide. In sharp contrast, contrast the number of agencies in states with CON regulation increased by only about 38% compared with nearly 135% in states that had eliminated CON regulation. The increase in Maryland was only 11% (Table A1, Appendix A).

The potential value of CON as a likely restraint on unnecessary agency development is supported by the reversal of this pattern of development nationwide between 1997 and 2000, following adoption of the Balanced Budget Act of 1997 and the launching of Operation Restore Trust by the Health Care Financing Administration. The number of Medicare-certified agencies declined by about 27% nationally between 1997 and 2000, but by only about 18% among states with CON programs compared with a 33% decline in states that eliminated CON regulation (Table A1, Appendix A). States with CON regulation exhibited a more stable development pattern both before and after adoption of the Balance Budget Act.

Though regulation of the number of certified home health agencies does not provide a firm control on capacity, it does appear to have had some influence in discouraging excess capacity and use. The use levels and patterns seen with the numbers of certified home health agencies is replicated in the data delineating the numbers of home health patients served by states during the 1990s. The number of patients served nationally increased by nearly 200% between 1991 and 1997. The number served in states that eliminated CON regulation increased by 246%, compared with an increase of only 145% in states that retained CON regulation and an increase of about 233% in states that have never regulated home health under CON (Table A2, Appendix A).

Total home health care demand is a function of the number of patients served and the number of visits delivered to each patient. Some of the volume and caseload differences observed among states reflect the wide variation among states in the average number of visits per user (patient). The average number of visits per user ranged from a low of 23 (South Dakota) to a high of 88 (Tennessee) in 1991, and from 32 (Washington) to 161 (Louisiana) in 1997 (Table A4, Appendix A). The average number of visits increased nationwide up to 1997, growing from 45 visits per user in 1991 to 73 visits per user in 1997. The average number of visits decreased sharply to 51 in 1998, following adoption of the Balanced Budget Act of 1997 and implementation of Operation Restore Trust. Regulation under CON does not appear to have had a direct bearing, if any, on the average number of visits per user observed among states. The ranges of the average number of visits per user among states with CON regulation, from 24 to 88 visits per user in 1991 and from 32 to 146 visits per user in 1997, do not differ greatly from the average in states that eliminated regulation, which ranged from 27 to 64 visits per user in 1991 and from 33 to 143 in 1997 (Table A4, Appendix A).

There are pronounced variations in the number of visits per user by type of agency providing the service and geographically (Map I). Proprietary (for profit) agencies have always tended to provide more visits per user than public and voluntary non-profit agencies. In 1987, for example, for-profit agencies nationally provided an average of 28 visits per user compared with 22 visits among non-profit agencies, a 27% differential. By 1997, proprietary agencies were providing an average of 104 visits per user, compared with an average of 53 visits among non-profit agencies, a 96% difference. It is also noteworthy that nearly all of the states with unusually high numbers of visits per user are southern states and all have a relatively high percentage of proprietary agencies.

These variations do not appear to be explained by population or health status differences across agency types, regions or states. Concern about these unexplained disparities, and about the economic implications of them, were part of the rationale

for the changes legislated in the Balanced Budget Act of 1997. The programmatic changes made and now being implemented are likely to narrow the variation among states and across agency types.

Average visits per user in Maryland have been consistently at the lower end of the ranges of use, both nationally and among states maintaining CON regulation of home health care agencies. Maryland Medicare beneficiaries obtaining home health care services from certified agencies in 1991 used an average of 32 visits and an average of 38 visits in 1997. Average visits per user decreased to 30 in Maryland in 1998, following implementation of the Balanced Budget Act (Table A4, Appendix A). The decrease was smaller than that seen in most states, particularly among southern states. The comparatively low number of visits per Medicare home health user in Maryland may be partially explained by the relatively small number of proprietary home health agencies in the state. As discussed below, it may also be affected by the comparatively high level of Medicaid expenditures in the state relative to Medicare benefits claimed.

Home health care expenditures, too, vary widely nationally and regionally. Medicare expenditure patterns at certified agencies roughly parallels the visits per user patterns observed. Although it is possible that CON regulation affects indirectly total home health care outlays by limiting the number of certified agencies that are operational, particularly the number of proprietary agencies, no direct relationship between the average payment per user and CON regulation is readily evident. There has been, and is, a wide range of average payments per user across states, irrespective of CON regulatory status of the states. Average payments per user ranged from \$1,534 to \$4,420 among states with CON regulation in 1991 and increased to from \$2,772 to \$8,605 in 1997. This compares with ranges of from \$1,300 to \$3,322 in 1991, and from \$2,596 to \$9,083 in 1997 for states that eliminated regulation. The median average expenditure per user was higher among states with CON regulation in 1991 (\$2,353) in states with regulation compared with \$2,141 in states that eliminated regulation. By 1997 the relationship was reversed, with the median average payment was \$4,069 in states that eliminated CON compared with \$3,826 in states with CON regulation (Table A8, Appendix A).

As with the average number of visits per user, to which total payment per user is necessarily closely related, there appears to be little if any relationship between CON regulation status and the average payment per user in Maryland. Average expenditures per user in Maryland have been and remained near the lower end of the range of payments nationally and among states with CON regulation. The average payment in Maryland was \$2,080 in 1991, increased to \$3,104 in 1994, before decreasing to \$2,980 in 1997 and then sharply downward to \$2,551 in 1998 (Table A8, Appendix A)

The percentage of Medicare enrollees that use home health services grew rapidly during the 1980s and 1990s, doubling between 1990 and 1997, the year the Balanced Budget Act was adopted. In 1990, about 5% of Medicare enrollees received home health benefits. By 1997 more than 10% of Medicare beneficiaries used home health services. The percentage of enrollees using home health care services has varied widely among states, ranging from 1% in Maine to 11% percent in Mississippi in 1991, and from 5% in Hawaii to 16% in Louisiana in 1997 (Table A5, Appendix A). Notwithstanding the wide variation among states generally, the percentage of enrollees using home health care does not appear to differ greatly in states with CON regulation compared with those that eliminated regulation or those that never regulated home health agencies.

Consistent with its comparatively low average number of visits per user and its low expenditure level per patient, the percentage of Maryland Medicare enrollees that use home health care has been modest and grew at a much slower than average pace during the 1990s. About 6% of Maryland Medicare enrollees used home health services in 1990, slightly above the national average (5%). The proportion grew to 9% by 1997, a 50% increase. Though substantial, this was the third smallest increase, nationally. Only Tennessee and Vermont had smaller percentage increases, 30% and 40% respectively, and the percentages of Medicare enrollees in those states using home health care were already higher in 1990 than the Maryland proportion in 1997 (Table A5, Appendix A). The explanation for this anomalous pattern is not evident from the data collected. There is no indication that it relates to CON regulation directly.

Age-specific use rates for home health services vary widely among states, nationally. In 1991, the range was from an atypical low of 7 patients per 1,000 persons 65 years of age and older in Hawaii to 92 per 1,000 in Rhode Island. Though it does seem to influence the number of certified agencies in a state, CON regulation does not appear to affect negatively home health agency population-based use rates. The number of home health patients and home health visits per 1,000 persons among those 65 years of age and older appear to be higher among states with CON regulation compared with rates in those states that eliminated regulation and those that never regulated home health agencies (Table 7).

The increase in use rates seen in Maryland between 1991 and 1997 was comparable to those seen in a majority of states. The underlying patient and patient visits rates, however, remained near the lower end of the ranges seen among states nationally (Table 7 and Tables A6 and A7, Appendix A).

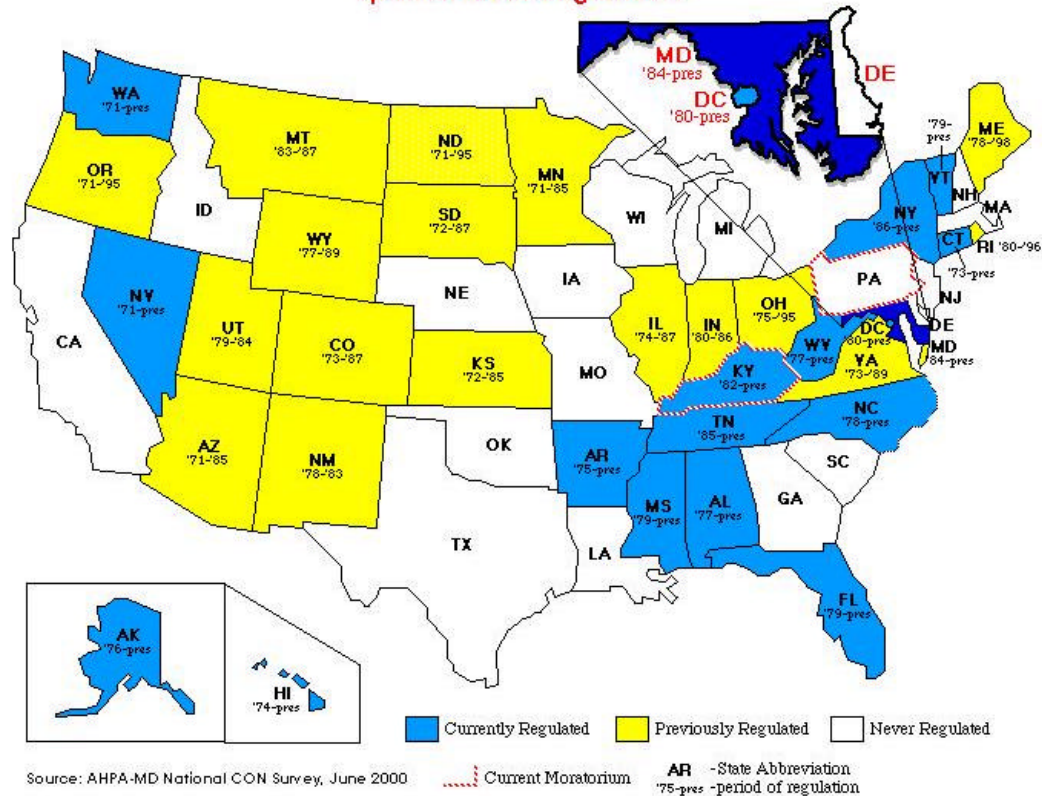
Table 7 Home Health Agency Use Rates By State and CON Regulation Status, US 1991 – 1997						
State Category	Patients per 1,000 Persons 65 Years and Older		Visits per 1,000 Persons 65 Years and Older		Percent Change 1991 - 1997	
	1991	1997	1991	1997	Patient Rate	Visit Rate
Continue Regulation (N=19)	48.9	110.6	2,340	8,285	126%	254%
Eliminated Regulation (N=20)	31.4	97.1	1,393	8,032	209%	477%
Never Regulated (N=12)	29.0	101.0	1,260	6,135	248%	387%
Maryland	26.7	86.4	873	3,106	224%	256%
United States	36.2	102.9	1,651	7,422	184%	350%
Source: Baseline Data, Tables A6 and A7, Appendix A						

B. Hospice Services

Relatively few states have regulated hospice services under state certificate of need programs in recent years. Currently, 17 states and the District of Columbia control hospice development under CON (Tables 10A-12A). As with home health services, there is a strong regional character to the pattern of regulation. More than two-thirds of the states regulating hospice development are located in the eastern third of the nation. They are concentrated in the Northeast and the South (Map II).

Map II: Hospice Facilities and Services (1971-2000)

Span of CON Regulation



No ready explanation for this distribution emerges from the development patterns observed. They may be more accidental than not. CON laws were already in place before there were hospices, or efforts to develop them, in many states. Depending on the statutory language, some state statutes were interpreted to include coverage, others to exclude coverage and require amendment if regulation were desired. Another consideration that appears to have affected the pattern of regulation is that, by the time hospice development became an issue in many states, the value of CON regulation itself was under challenge nationally and in many states. Consequently, few states added hospice as a covered service after the early 1980s, and a number of states dropped coverage shortly thereafter. Although the movement to develop hospices was gaining momentum nationwide in the early 1980s, with Medicare adding it as a covered service in 1983, only four states, Kentucky, Maryland, North Carolina and Tennessee, extended CON regulation to hospice services after 1980. Sixteen states never included hospice services in their CON programs. By 1991 there were 951 Medicare certified hospices nationwide. Slightly more than one-third of these (35%) were located in states with CON regulation of hospice services (Table 8). By 1997, the number of certified hospices had grown to 2,327, an increase of 145%. Implementation of the Balanced Budget Act of 1997, which affected the ability of some home health agencies to offer hospice services, appears

to have affected hospice development and operations somewhat. The number of certified programs decreased to 2,290 in 2000, following adoption of the legislation.

Table 8 Number of Hospices By State CON Regulatory Status 1991 – 2000					
State/Category	Number of Hospices			Percent Change	
	1991	1997	2000	1991 -1997	1997 – 2000
With CON Regulation (N=18)	273	632	617	132%	-2.4%
Without CON Regulation (N=17)	364	835	820	129%	-1.8%
Never Regulated (N=16)	314	860	853	174%	-0.8%
Maryland	25	35	31	40%	-11.4%
United States	951	2,327	2,290	145%	-1.6%
Source: Baseline Data, Table A10 Appendix A.					

These data suggest that, though it may have provided useful scrutiny of some hospice development projects, CON regulation was not an obstacle to the development of needed hospice services in states that retained regulation in the 1990s. Though the rate of growth in states with CON regulation was notably lower than in states that never regulated hospice development under CON, it was slightly higher than the rate of growth in states that eliminated regulation (Table A10, Appendix A).

Maryland had 25 hospices in 1991, a comparatively large number. The number grew to 35 in 1997, a 40% increase. This was a relatively slow rate of growth, compared with triple digit growth rates in the majority of other states. The loss of four Medicare certified hospices between 1997 and 2000 in Maryland is disproportionate, but if these changes resulted from mergers and consolidations of services the end results are likely to be benign.

Unlike with home health agencies generally, the Balanced Budget Act of 1997 appears to have had only modest effects on the numbers of hospice programs nationwide, and the aggregate numbers do not appear to differ significantly by state regulatory status (Table A10, Appendix A).

The growth in hospice patient volumes far exceeded the growth in the numbers of certified hospice agencies during the 1990s in all state regulatory categories (Tables 8 and 9). Thus, there was a substantial increase in the average number of patients served by each certified program.

Table 9
Number of Hospice Patients
By State CON Regulatory Status
1991 – 1997

State/Category	Number of Hospice Patients		Percent Change
	1991	1997	1991 -1997
Continue Regulation (N= 18)	15,558	124,342	699%
Eliminated Regulation (N=17)	14,015	153,769	997%
Never Regulated (N=16)	13,914	123,866	794%
Maryland	1,328	5,590	321%
United States	43,487	401,977	824%
Source: Baseline Data, Table A11 Appendix A.			

Between 1991 and 1997, the average number of patients served per hospice nationally grew from 46 to 173. The average number of patients served in states with CON regulation increased from 57 patients to 197, compared with an increase from 39 to 184 patients in states that eliminated CON regulation and an increase from 65 to 144 patients in states that never regulated the establishment of hospices. By contrast, the Maryland average grew from 53 to 160 patients. These changes reflect growing acceptance and demand for hospice care, the maturation of the service in many communities. There do not appear to be significant disparities among states by CON regulation status.

In recent years, between two-thirds and three-fourths of those using hospice services have been 65 years of age and older. Age-specific use rates vary widely across states nationally (Table A12, Appendix A). The range in 1997 was extreme, from about 38 patients per 10,000 persons 65 years of age and older in Alaska to nearly 750 per 10,000 in Colorado. Excluding these two extremes, the range was from about 50 per 10,000 in Maine to about 192 in Arizona. Use rates by state regulatory status show far less divergence (Table 10).

Table 10 Hospice Use Rates By State CON Regulatory Status 1991 – 1997			
State/Category	Patients per 10,000 Persons 65 Years of Age and Older 1991 1997		Percent Change 1991 -1997
Continue Regulation (N=18)	13.4	96.8	622%
Eliminated Regulation (N=17)	13.2	133.0	908%
Never Regulated (N=16)	13.2	109.5	730%
Maryland	25.1	95.6	280%
United States	13.7	116.5	750%
Source: Baseline Data, Table A12 Appendix A.			

CON regulatory status does not appear to be meaningfully related to the average state hospice use rate. Elimination of the extremes (Alaska and Colorado) results in roughly similar use rate levels across state groupings. It is notable that the use rates were substantially higher in Maryland in 1991 than nationally and in most other states, regardless of CON regulatory status. This probably reflects the earlier development and maturation of the hospice movement in Maryland, compared with most states. More recent use rates in Maryland are roughly comparable to those in the majority of other states. Maryland use rates do not appear to be related to CON regulation status.

VI. Maryland Patterns

Home health care and hospice service development and use patterns vary widely by region and by state. Hospice development and use patterns in Maryland do not differ greatly from those found elsewhere. By contrast, patterns for home health services are distinctive. Capacity, use levels, use rates and expenditure levels have been and remain notably low. Maryland was one of a handful of states that saw little growth in the number of certified agencies during the 1990s. Nationally, the number of agencies grew from 5,708 in 1990 to 9,376 in 1998, a net increase of 63%. The number in Maryland grew from 73 to 81 in 1997 and then fell to 77 in 1998, for a net gain of 5% between 1990 and 1998.²¹

The percentage of Medicare enrollees using home health care services, nationally, increased from 6% in 1990 to about 11% in 1997, an increase of about 83%. In 1990, a comparable 6% of Maryland enrollees obtained home health care services.

The percentage grew to 9% in 1997, an increase of 50% but still far below the national average and that of all other states except three: Mississippi, Tennessee, and Vermont. The average number of Medicare home health visits per patient in Maryland was even lower. Nationally, the average number of Medicare home health visits per patient doubled over the decade, increasing from 36 in 1990 to 73 in 1997. By contrast, the average number of visits per patient increased only 28% in Maryland, going from 29 to 36 visits per patient between 1990 and 1997. This was the lowest rate of growth, nationally, and brought Maryland Medicare enrollees only to the national use level that prevailed in the late 1980s (Table A4, Appendix A).

To some degree the small growth in the number of agencies was offset by a larger than average growth in the number of staff employed by agencies in Maryland. For the eight-year period 1990 to 1998, the number of staff at certified home health agencies increased by 151%. The increase among Maryland agencies was considerably higher at 186% (Table A9, Appendix A). This was an effective increase in capacity, and reflects higher caseloads per agency. The higher average caseloads (patients and visits per agency) in Maryland may also be the result of mergers and other forms of consolidations of home health agencies in recent years.

Medicare home health expenditures per patient varied widely by state, with a 1997 range of more than 300% between the lowest (Iowa at \$2,562) and the highest (Louisiana at \$9,278). Maryland expenditures per patient were a comparatively low \$3,088 per patient in 1997, making it the eighth least costly. The rate of increase in expenditures per Maryland patient, 42% between 1990 and 1997, was the second lowest nationally. It was second only to Vermont (38%), and was tied with Washington, also 42%, for second lowest.²²

These wide variations are surprising given the common Medicare program enrollee population base. They are not fully explained by the age, gender or health and functional status variations among patients by the state residence of program beneficiaries. Factors or considerations that may be responsible include physician prescribing practices, the business practices of home health agencies and the strength and role of the state Medicaid program in providing home health services to the medically indigent.

Some research appears to support the conclusion that home health care use levels, and consequently development and expenditure levels, are influenced by state Medicaid program policies and coverage.²³ More than a few states have adopted policies and strategies to shift as much cost as possible from state Medicaid programs to the Federal Medicare program, thereby reducing state expenditures for health care. Home health care is one of the services frequently targeted by such policies and initiatives.²⁴

Those examining the interaction between Medicare-certified home health agency program volumes and expenditures, and those of state Medicaid programs, have divided states into four categories:

- those with high Medicare and high Medicaid expenditures;
- those with high Medicare and low Medicaid expenditures;
- those with low Medicare and high Medicaid expenditures; and
- those with low Medicare and low Medicaid expenditures.

Investigators found a weak but significant inverse relationship between Medicare and state Medicaid program spending for home health care services. Under this classification scheme, Maryland is one of fifteen states that falls into the low Medicare-high Medicaid category. This may partially explain the unusually low use and expenditure patterns for home health services observed among Maryland Medicare program enrollees over the last decade and a half.

Some of the capacity, use and expenditure data found in Tables A1 - A9 (arrayed by state CON regulation status) is presented in Tables A13 - A21 by the four state Medicare-Medicaid expenditure categories described above. Maryland capacity, use and expenditure levels fit reasonably well within the low Medicare/high Medicaid state profile. Viewed from the perspective of Medicare-Medicaid policy interaction and expenditure levels, Maryland's home health service capacity, use and spending patterns are not especially anomalous. Maryland's experience falls well within the ranges observed among the low Medicare/high Medicaid states nationally.

VII. Perceived CON Regulation Experience: Follow-Up Questionnaire Response

Although no combination of states fits two of the three profiles called for in the original survey design, officials in six states were surveyed to obtain as much information as possible about their experience with the regulation and deregulation of home health and hospice services. The six states surveyed were Connecticut, Indiana, Kentucky, New York, Virginia and Wisconsin. Certificate of need, licensing, and Medicaid program officials in each state were surveyed, as were representatives of relevant state provider organizations. Appendix C contains copies of the survey instruments.

State experiences vary, but a number of general themes emerged. Prominent among them were:²⁵

- Nearly all CON and licensing officials reported major increases in the number of home health agencies and hospices in the decade between the late 1980s

and the late 1990s, regardless of regulatory status. Increases were somewhat larger in states that eliminated regulation of home health and hospice services than in those that maintained regulation. These views were supported by the impressions and observations of representatives of state provider associations. State Medicaid program officials provided relatively little factual data or information, and were unusually reluctant to express organization or individual views or opinions.

- None of the states that have never regulated home health or hospice services, or had eliminated regulation of either service, substituted formal licensing or Medicaid program standards to limit or otherwise control home health or hospice services. States without moratoria apparently did not consider substituting a moratorium for CON regulation.
- Only New York, which regulates home health and hospice services under CON, and has imposed a moratorium on establishing new home health services, reported little if any increase in the number of home health agencies. Kentucky also regulates home health and hospice services and has imposed a moratorium on new home health agencies, but interviewees in the state still reported a significant increase in the number of agencies and service volumes.
- Assessment of access to home health services was mixed. Most of those surveyed reported that access improved early during the 1990s, but may have begun to deteriorate recently. Broader program coverage and consolidation of agencies into larger and more capable organizations were credited with improving access. Officials in New York and Virginia reported deteriorating access resulting from manpower shortages and changes brought about by the Balanced Budget Act of 1997.
- All states reported improved access to hospice services, particularly access to home care services, regardless of state regulatory status. Improved access was attributed to broader Medicare and Medicaid program coverage, and to more efficient hospice program operations.
- All states reported increased demand for both home health and hospice services, and higher use rates, regardless of state regulatory status.
- Those surveyed had little reliable information on changes in quality or in capital or operating costs, regardless of state regulatory status. None of those surveyed reported published studies documenting the effects of CON regulation, or the elimination of such regulation, of either service.
- None of those surveyed in states that never regulated either service, or in states that had eliminated CON regulation in either service, favored the

imposition of regulation or believed other informed persons favored regulation. Most thought that the re-imposition of planning controls would have little or no effect on the development or operation of either service. The majority of those surveyed in states with CON regulation favored continued regulation, but a number favored deregulation on that grounds that CON regulation of these services is not noticeably effective.

- No major problems were identified that could be anticipated if CON regulation were eliminated for either service.

VIII. Moratoria and Planning Standards

Four states report having current moratoria on new home health agency development and two on new hospice development. Three of the four states with home health agency moratoria, Kentucky, Mississippi and New York, also regulate home agencies under state CON laws. Pennsylvania, the other state with a moratorium on home health agency development, never regulated home health agencies under its CON program. Two of the four states with home health agency moratoria also have imposed moratoria on the development of new hospice programs. Kentucky and Pennsylvania report having moratoria on hospice development currently in place.

Several other states have had moratoria on the development of these services at some point over the last fifteen years. Reasons for imposing both CON regulation and a moratorium on development tend to be idiosyncratic, specific to the circumstances and political climates of the states involved. Because most of the states with moratoria also maintain CON regulation, it is difficult to determine the relative affects of each. The data reported suggest that moratoria help limit the development of new services and thereby presumably affect related operations. But because the circumstances, timing, duration and rationale for moratoria vary, no clear pattern or trend of effects emerge from the state data reported. Tables A1 – A21 in Appendix A contain comparable data for state with and without moratoria by state CON regulation status.

A number of states have adopted specific criteria and standards for use in the planning and regulation of home health and hospice services. Attachment I contains copies of the regulations and plans currently in use by states that regulate home health and hospice service development.

IX. Conclusions and Observations: General

CON regulation patterns for home health and hospice services among states have changed markedly over the last two decades. In the early 1980s, about 76% of states (38 states and the District of Columbia) included home health agencies in their CON

programs and about 70% (35 states and the District of Columbia) included hospice services. Currently, only 19 jurisdictions regulate home health services and 18 jurisdictions regulate hospice development. There are distinct geographic patterns among states that retain CON regulation of these services. States that regulate them are concentrated in the east, particularly in the northeast and the southeast.

Although there is no evidence of more intensive regulation of home health or hospice services, there has been relatively little change in the patterns of regulation in recent years. Of the 32 jurisdictions that do not have CON regulation of home health services, 12 never instituted regulation and 15 of the 20 states that have eliminated regulation did so more than a decade ago. Four states dropped regulation in the 1990s. The pattern with hospice services is similar. Of the 33 jurisdictions that do not have CON regulation of hospice development, 16 never instituted coverage and 13 of the 17 that eliminated regulation did so in the 1980s. Four states dropped regulation in the 1990s.

These patterns are related to that seen with nursing home services. All states that have eliminated CON regulation of nursing home services either never regulated home health and hospice services or have dropped coverage of both. Some states that have tried to maximize Medicare payments for long-term care services, and thereby reduce Medicaid and other state expenditures, have promoted home health care as an alternative form of care where possible. Some of these states may have effectively loosened controls on home health services to promote the shift in expenditure and revenue patterns. Few states that do not regulate home health and hospice service development employ moratoria or other market entry limits, whereas a substantial number of states do employ moratoria and other market entry controls for nursing home services (Tables A1-A12).

State regulatory patterns and trends suggest that CON regulation does limit market entry by controlling the numbers of home health agencies and hospices that are established. The number and rates of growth of home health agencies and hospices in states with CON regulation was lower during the 1990s than in states that eliminated regulation or never regulated the services. Because existing home health and hospice services can effectively expand capacity by adding staff, CON regulation does not control their day-to-day capacity or their ability to meet demand locally.

Overall costs, the number of visits per patient, and expenditures per patient do not appear to be affected directly by CON regulation. The range of visits per user, expenditures per patient, and total expenditures is wide in all regulatory categories. Taken collectively, the data do suggest that CON regulation may have indirect effects on overall use, costs and expenditures. There are proportionately fewer proprietary agencies in states with CON, and for-profit agencies have notably higher charges and numbers of visits per user than do non-profit and public agencies. Given that more than half of all agencies created are proprietary, limiting the number of

agencies established is likely to act as a brake on overall use, charges and expenditures.

It is possible, but not certain, that CON regulation has a sentinel effect on the development and operations of home health and hospice services. It is also possible that other forms of oversight might be structured to have equal or similar effects. The disclosure and scrutiny that the CON review and approval process entails may provide needed public oversight of the economic, quality and related service provision aspects of home health agency and hospice operations. This function may be equally useful during periods of excess, when extraordinary efforts are being made to maximize Medicare payments by shifting both patients and costs to programs such as home health care that are largely Medicare funded, and in the subsequent periods of reaction when stern measures are adopted to correct excesses that have arisen. It may be more than coincidental that the worst of the excesses uncovered by Operation Restore Trust were concentrated in states without CON regulations and the subsequent reduction in capacity and use was less pronounced in states with CON regulation. On the whole, there appears to have been greater stability in states with regulation.

X. Conclusions and Observations: Maryland

Maryland regulates both home health care and hospice services under CON, and has done so since 1984. The duration of regulation in Maryland is notably shorter than in most states that continue to regulate these services. Over this period a distinct capacity and use profile has emerged.

Home health and hospice activity levels are comparatively low in Maryland. It was one of a handful of states that saw little growth in the number of certified home health agencies and hospices during the 1990s. Growth rates in both were near the lower end of the range seen across states nationally. Demand and service use levels, too, are relatively, but not exceptionally low. The age-adjusted home health care use rate, expressed as the number of home health patients per 1,000 persons 65 years of age and older, was about 84% of the national level in 1997. If the extraordinarily high rates in states with known excesses are excluded, the Maryland rate is roughly comparable to that found nationally. The hospice use rate, expressed as the number of hospice patients per 1,000 persons 65 years of age and older, was about 82% of the national rate in 1997 and was generally comparable to that of other states with CON regulation. Again, if the experiences of the few extraordinary states are excluded, the Maryland rate is comparable to that found nationally. Both rates are generally consistent with those seen in the low Medicare/high Medicaid states.

The one measure of use in Maryland that is extraordinarily low is the number of visits per user of home health services. The 1997 Maryland rate was only about 42% of

the national level and was one of the lower rates, nationally. The reason for this is not well understood, and may be worthy of more intensive study. It is not necessarily negative, however, given the extraordinary excesses documented in a number of states with unusually high use, it may be nearer to what should be the norm than first appears. The Maryland average number of visits per patient is only slightly below the average of states categorized as low Medicare/high Medicaid states.

Notes

¹ For a history of CON programs up to the repeal of P.L. 93-641 see James B. Simpson, "Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control," *Indiana Law Review*, Volume 19, No. 4, 1986.

² Spiegel, AD, Domanowski, GF, "Beginnings of Home Health Care: A Brief History." *Journal of Long Term Home Health Care* 2(3):28-33, 1983.

³ *A Profile of Medicare Home Health: A Chart Book*. Office of Strategic Planning, HCFA, DHHS. August, 1999, p. 44.

⁴ *Basic Statistics About Home Care*. National Association for Home Care. March 2000, pp. 1-8.

⁵ U. S. Census Bureau, 1997 Economic Census (October 8, 1999), cited in National Association for Home Care, "Basic Statistics About Home Care, March 2000.

⁶ Levit KR, Lazenby, HC, Braden, BR. *et. al.*, National Health Expenditures, 1996. *Health Care Financing Review*, 19(1): 161-200, 1997.

⁷ *A Profile of Medicare Home Health: A Chart Book*. Office of Strategic Planning, HCFA, DHHS. August 1999, p. 81.

⁸ *Ibid.* p. 82.

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²⁵ The detailed responses of those interviewed are included separately as an attachment (Attachment I) to this report.